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ABSTRACT

The documented incidence of sexual abuse of boys is reported. Though prevalence rates varied from different sources, all sources agreed that reported cases reflect only a fraction of the actual prevalence. The paper also discusses characteristics of the abusers, risk factors of victims, the effects of abuse, and the coping styles of the young male victims. A section on assessment discusses what to assess and how to assess. Treatment methods described include group, individual, and family therapy. Treatment tasks focus on ensuring safety for the child victim, encouraging the boy to talk candidly about what occurred, and getting in touch with feelings. Ways of assessing and treating sexualized acting out in abuse-reactive children are also explored. Annotations of 12 publications are provided, as well as a 78-item reference list for professionals. (JDD)

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Sexually Victimized Boys

Sexual abuse of boys has been overlooked or minimized. Very little is written that specifically addresses the effects of sexual abuse on male children. Boy victims have not been readily identified and even when identified, parents have not often sought treatment for their male children. Thus, there is little to guide the clinician in the assessment and treatment of this population.

Incidence

It is difficult to compare incidence studies, as researchers have no common definition of either childhood or sexual abuse. Random population samples are the exception. Many prevalence studies look only at rates of victimization for females or have extremely small samples of males.

The most common method of study appears to be questioning adults about their sexual experiences as a child. One of the earlier studies, a survey of New England college students, found a rate of 8.7 percent reporting sexual activity with a partner five or more years older if under 13 and 10 or more years older if 13 to 16. The rate of sexual abuse for boys under 13 was 4.1 percent (Finkelhor, 1979).

A University of Washington study (Fritz, Stoll and Wagner, 1981) surveyed college students. Out of a sample of 410 males, 4.8 percent said that they had prepubertal physical sexual contact with an adult. Readers should note that this study excludes adolescents, both as offenders and victims, thus excluding a sizeable proportion of sexual offenses. Other surveys of college students (Bagley, Little, Robertson and Sorrenti, 1984; Calhoun, Kilpatrick and Seidner, 1985, both cited in Salter, 1988) showed rates of five percent and 11 percent respectively.

Studies using college populations have a disadvantage in underrepresenting the lower socioeconomic levels. Finkelhor found in his 1979 study that lower-income females were 60 percent more likely to experience both extrafamilial and intrafamilial child sexual abuse than were middle-income females. Thus, it is possible that studies utilizing college populations underestimate the incidence rates due to socioeconomic sample bias (Salter, 1988).

Several other studies use community samples. Finkelhor (1984), in a 1981 survey of Boston fathers, found six percent reported sexual abuse as a child (3.2 percent prior to age 13). A 1978 random survey of Texas residents with valid driver's licenses (Kercher & McShane, 1984) found three percent of 461 males reporting sexual abuse. And Badgley (1984, as cited in Salter, 1988) in a Canadian national random survey with a sample of 1002 found nine percent reported sexual abuse prior to age 18 and six percent reported sexual abuse prior to age 16.

In a review of all prior studies, Finkelhor (1984) concludes that the "true prevalence figure" for sexual abuse experiences of boys under 13 might be between 2.5 and 5 percent.

Including those 13 to 18 raises the estimate to between 2.5 and 9.7 percent. How does the incidence of sexual abuse of boys compare to that for girls? Finkelhor (1984) in his review of incidence studies concludes that two to three girls are victimized for every boy. His review of research showed rates ranging from 2:1 to almost 10:1.

For example, a retrospective review of 145 sexual abuse cases seen at Children's Hospital of Buffalo in 1976 to 1978 showed that 11 percent of the victims were male (Ellerstein and Canavan, 1980). A similar review of 1,748 sexual abuse victims examined at Children's Hospital and Health Center from 1979 to 1984 showed that 9 percent were boys (Spencer and Dunklee, 1986). These two studies are typical of others performed at major medical centers showing males to be between 11 and 16.4 percent of identified child sexual abuse victims (Blanton, 1981; DeFrancis, 1969; Dynneson, Jaffe and Ten Bensel, 1975; Pierce and Pierce, 1985; Reinhart, 1987).

Clinicians interviewed by VCPN, however, disagreed. "I think the ratio is 50-50,"

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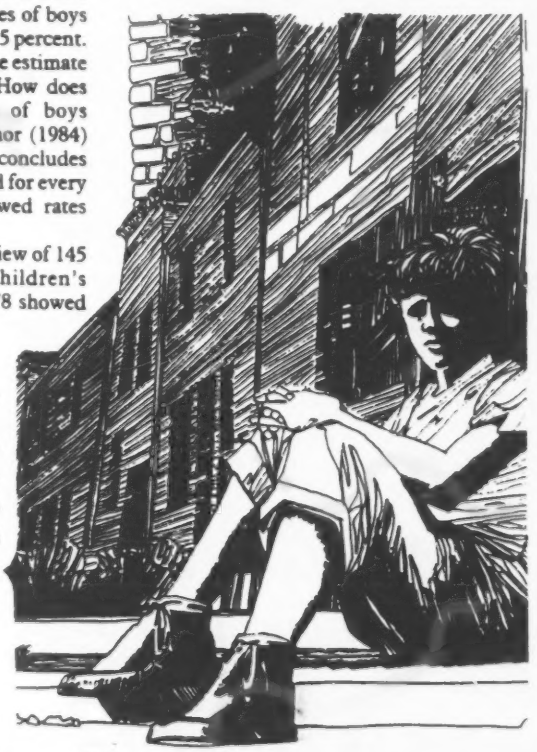

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Abuse of Boys

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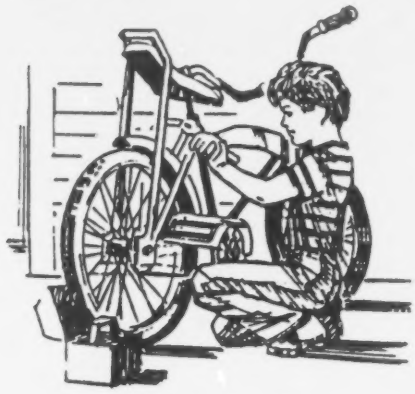

stated Paul Gerber, M.A., director of the Male Victims Program at East Communities Family Services and a nationally known expert on male victimization. "Boys are at equal risk as girls," agreed Eugene Porter, M.A., author of "Treating the Young Male Victim of Sexual Assault: Issues & Intervention Strategies" (see review, this issue).

Support for the idea of a "50-50" ratio was found in one research study. Random-probability samples in Los Angeles, Denver, Omaha, Louisville and Washington, D.C., yielded a total of 4,340 adults who answered an extensive questionnaire regarding sexual attitudes, activities and experiences (Cameron, P., Coburn, Larson, Proctor, Forde and Cameron, K., 1986). Results indicated that approximately equal percentages of men and women (16 percent) claimed sexual relations with an adult before age 16. Prior to age 13, nine percent of boys and seven percent of girls claimed sexual activity with adults.

Underreporting

Regardless of the actual prevalence of sexual abuse of males, all sources consulted agreed that the reported cases reflect only a fraction of the actual number. For example, the National Incidence Study of Child Abuse and Neglect (NCCAN, 1981) estimated 7,600 cases of sexually abused boys known to professionals in the United States for 1979. Assuming a 2.5 percent rate (the lowest rate of the incidence studies already discussed), a total of 550,000 of the current 20 million boys under 13 have been sexually abused. To produce this number, approximately 46,000 new victimizations would have to occur each year (Finkelhor, 1984).

The fact that general surveys show much higher rates of male victimization than child protective service reports, clinical studies and hospital records strongly suggests that sexual abuse of boys is not reported and that treatment is not sought frequently for male victims.

Why does underreporting occur? It is difficult for *any* child to report sexual abuse. Children typically fail to report abuse because they feel guilty about the behavior, because of threats they have received or because they fear they will not be believed. The child's relationship with the offender may be the only positive relationship available and the child may fear losing the offender.

In addition to the pressures which also affect girls, boys have additional reasons for silence. First, boys are taught by our culture that males simply are not victims (Nasjleti, 1980). "If men aren't to be victims, then victims aren't men" (Lew, 1988, p. 63). Thus, for a male to admit to being a victim is to deny his manhood.

Second, men in our culture are taught to "tough it out" rather than to ask for help. Even if a boy is able to define his experience as victimization or "being ripped off," he is likely to regard the consequences as his problem rather than asking for help.

Third, most adult sexual offenders are male. Our society is homophobic, and many young males assume that they were selected for sexual activity by a male because of some homosexual attribute. Thus, to admit to a homosexual assault is tantamount to admitting to homosexuality (Nielsen, 1983). Others believe that homosexual molestation will cause them to become homosexual. Not wanting to be labeled by peers and others as "gay" should the assault become known, the male victim "suffers in silence" (Nasjleti, 1980).

If the perpetrator was a woman, the boy may feel that others will ridicule him or not take the abuse seriously. After all, males with early sexual experience are regarded as precocious and lucky. If the abuser was his mother, some boys may fear that the molestation is proof that they are mentally ill (Nasjleti, 1980). The strongest cultural taboos against molestation are toward mothers and these make reporting more devastating for a son (Krug, 1989).

Fourth, boys may fear being punished or held responsible for the abuse. The general public believes that boys are capable of self-defense and preventing sexual abuse. Boys who report sexual abuse frequently encounter either disbelief or blame (Nasjleti, 1980).

Fifth, boys may fail to report due the to fear of loss of freedom and restriction of their activities. Traditionally in our culture, boys are allowed more independence than girls. A predictable consequence of informing one's parents of sexual abuse would be limitation of unsupervised activities (Nielsen, 1980).

Finally, male victims may fail to report sexual molestation with adults because the boys in some cases do not perceive the sexual activity as abusive. This perception may be due to denial or minimization in order to avoid overwhelming and unacceptable feelings of helplessness. Whatever the reason, researchers have found that some male victims report neutral or positive effects of sexual activity with adults (Brown, Condy, Templer & Veaco, 1987; Fritz, et al, 1981; Johnson & Shrier, 1985; Sandfort, 1984).

Characteristics of the Abusers

Researchers agree that perpetrators against children are overwhelmingly male (Dunklee and Spencer, 1986; Farber, Johnston, Joseph, Oshins & Showers, 1983; Finkelhor, 1984; Fritz, et al, 1981; Mey, 1988; Pierce and Pierce, 1985; Reinhart, 1987). For a discussion of female perpetrators, see VCPN, volume 27.

Most studies show that boys, like girls, are generally abused by a family member or acquaintance. However, boys are more likely than girls to be molested by a stranger. For example, Canavan and Ellerstein's (1980) study found that only 44 percent of the victimized boys knew their assailant. Reinhart's (1987) study was discrepant showing only a four percent rate of sexual abuse by strangers.

Natural fathers seem under-represented. Pierce and Pierce (1985) found males were significantly less likely to be sexually abused by a natural father (20 percent of boys compared to 41 percent of girls). This is similar to findings of other studies (Spencer and Dunklee, 1986, found 14 percent, Canavan and Ellerstein, 1980, found 7 percent), but different from Friedrich, Beilke & Urquiza's (1988) sample where 48 percent of the perpetrators were natural fathers.

For those boys who are abused by their natural father, often female siblings are also abused (Finkelhor, 1984). For example, Pierce and Pierce (1985) found abuse of multiple children in 40 percent of cases; Dixon, Arnorld & Calestro (1978) in 84 percent of cases; Spencer and Dunklee (1986) in 18 percent; Farber, et al (1983) 28 percent; and Nielson (1983) in 60 percent. Thus, it is not surprising that boys who are victimized alone are four times more likely to be victimized by a non-family member than boys who are victimized in tandem with girls (Finkelhor, 1984).

It is interesting to note that an appreciable number of identified male victims are sexually abused by adolescents. From 12 to 57 percent of the samples were victims of juvenile perpetrators (Canavan and Ellerstein, 1980; Condy, Templer, Brown and Veaco, 1987; Reinhart, 1987; Showers, Farber, Joseph & Oshine, 1983; Spencer and Dunklee, 1986).

Molesters appear more likely to use physical abuse with boy victims than with girls. Farber et al (1983) found physical violence in 22 percent of cases. Nielsen (1983) stated that boys are four times more likely than girls to suffer physical abuse. Similar findings were cited by Pierce and Pierce (1985), May (1988), Dixon et al (1978), Showers et al (1983) and Pierce (1987).

Most researchers agree that boys are more likely than girls to suffer from multiple types of sexual abuse. Rates of anal penetration are high, ranging from 47 percent to 76 percent (Dunklee & Spencer, 1986; Farber, Showers, Johnson, Joseph & Oshins, 1984;

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Reinhart, 1987). Fellatio is also common, with studies showing 43 to 60 percent of the male victims reporting engaging in this activity (Dunklee & Spencer, 1986; Farber et al, 1984; Pierce & Pierce, 1985). In contrast, fondling, which is common in molestation of females, is reported much less frequently (from 24 to 32 percent) (Dunklee & Spencer, 1986; Pierce & Pierce, 1985).

The types of sexual abuse common in male victimization, plus the higher rates of physical abuse, may account for the high percentage of boys with physical findings. Physical damage in samples studied included rectal lacerations, abrasions, scars, fecal leaking or incontinence, decreased anal tone and venereal disease. From 32 to 68 percent of male victims showed such damage (Canavan & Ellerstein, 1980; Dunklee & Spencer, 1986; Reinhart, 1987; Showers et al, 1983). On the other hand, the high percentage of physical findings in boys may mean that only the most severe cases are being identified.

Some authors (Geiser, 1979) maintain that the dynamics of males who sexually abuse boys have little in common with the dynamics of sexual abuse of boys by females. However, very little is known about females who abuse boys. Approximately half of the women who abuse children do so in conjunction with a male offender. There is limited data on women who abuse without a partner, but these perpetrators seem equally likely to choose girl victims as boys.

Only a few resources discussed males who sexually abused male children. Several authors stressed that most males who sexually abused boys are heterosexual in orientation, choosing male children as a convenience rather than a preference (Newton, 1978; Nielson, 1983). Heterosexual child molesters, presumably, have or will molest girls as well as boys. Thus, it appears unlikely that distinct differences will appear between males who molest boys and males who molest girls since a large percentage of men who molest children will, if given the opportunity, molest children of either sex.

A few additional studies offer data about the characteristics of the offenders. Chronic substance abuse is mentioned as a factor in a small number of cases, accounting for less than one-third of the offenders (Dixon et al, 1978; Dunklee and Spencer, 1986; Pierce and Pierce, 1985).

At least one study (Langley, Sehwartz and Faubaun, 1988) cites a history of homosexual sexual abuse of the perpetrator as a child. This is also not an unusual finding in male offenders who victimize female children. Likewise, findings that males who molest boys lack impulse control and have emotional, social and psychological problems (Mey, 1988; Pierce and Pierce, 1985) do not distinguish them from males who sexually abuse girls.

One researcher (Pierce, 1987) has, on the basis of a literature review of 52 cases, offered a typology of family situations in which a son may be abused by his father. These are the homosexual family, promiscuous family and violent family.

According to Pierce, homosexuality was a factor in only six of the 52 cases reviewed. Abuse generally began during the child's adolescence. After mothers become aware of the problem, they generally acted as allies to the children.

A more frequent finding was a chaotic family situation in which several children were sexually abused. The fathers in these families showed multiple problems and appeared to be seriously psychologically disturbed. Mothers were often involved in the abuse and saw no need to protect their sons. Sexual abuse began early in the child's life and was an intergenerational problem. In the violent families, sexual abuse usually began early in the child's life. Physical abuse of both the children and the spouse was present. Mothers in these families were overwhelmed, frightened and unable to confront their husbands or emotionally support the children.

In summary, most studies to date fail to show clear-cut differences between sexual offenders who molest boys and those who molest girls. Current data shows that those who molest boys, compared to molestation of girls, are more likely to physically damage the child and/or physically abuse the child. Perpetrators engage in a wider range of sexual activity with boys and boys are more likely than girls to experience anal intercourse, oral-genital contact, ejaculation and mutual masturbation.

The relative lack of differences between abuse of male and female children suggests that the sex of the child is not a key variable in the perpetrator's actions and motivations. The major influence in choosing a boy or a girl may be availability and convenience, rather than gender preference. The attraction to a child is the presence of a helpless victim who can be overpowered physically and emotionally with minimal risk of discovery.

Risk Factors

Are some male children more at risk for sexual abuse than others? The answer appears to be a decided "yes" for some variables.

Offenders seek out boys who are emotionally troubled or in need of attention and affection (Mey, 1988; Nielson, 1983). Increased risk is seen for boys in single parent families (Blanchard, 1986; Finkelhor, 1984; Mey, 1988; Pierce & Pierce, 1985) and in families from lower socio-economic class (Blanchard, 1986; Condy et al, 1987; Finkelhor, 1984).

Some authors maintain that boys are abused at a younger age than girls. Pierce and Pierce (1985) found an average age of 8.6 years, while Reinhart's (1987) sample averaged 5.9 years. Finkelhor's study showed an average age of 9.4 for father-son incest and 7.8 for mother-son, both considerably lower than the average age of the girls. A most sensible outlook on age is proposed by Showers, et al (1983) who found an age range of 8 months to 17 years in their sample. They concluded that boys of all ages are at risk for sexual abuse.

Boys are at higher risk for molestation outside the home and by adolescents, as discussed previously (Finkelhor, 1984; Fritz et al, 1981; Mey, 1988; Reinhart, 1987; Spencer & Dunklee, 1986). If abused within the home, it is likely that siblings have also been sexually abused (Finkelhor, 1984; Mey, 1988; Pierce & Pierce, 1985; Reinhart, 1987). Indeed, many cases of in-home sexual abuse of boys came to light only in the course of investigating a complaint of father-daughter incest.

Effects

A few authors minimize or discount negative effects of sexual abuse on male children (Bernard, 1981; Brown, 1987; Condy et al, 1987; Fritz et al, 1981; Ingram, 1981; Johnson & Shrier, 1985; Sandfort, 1984; Yorukoglu & Kemph, 1966). The overwhelming majority of studies, however, have documented a wide range of negative effects on male victims.

Boys who are sexually abused appear to suffer many of the same effects as girls. For preschool children, these include regressive behaviors (such as tantrums, separation anxiety, clinging, decreased ability to handle

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emotion and problems with wetting or soiling), sleep disturbances and nightmares, overactivity, agitation, increase in aggression and highly sexualized behaviors (such as compulsive acts, excessive masturbation, grabbing at adult's sexual organs, inserting objects into the anus and acting out with dolls or children).

School age children internalize more than younger children. Effects are likely to appear as depression or withdrawal, psychosomatic symptoms, changes in school performance, mood swings, irritability, and sleep and eating disturbances.

Adolescents are capable of greater acting out and symptoms may be more exaggerated. School failure or drop-out may occur, along with drug or alcohol abuse. Some teens become accident-prone, engage in self-mutilation or attempt suicide. Eating disorders, if present, worsen. Some male victims, like their female counterparts, become promiscuous.

In addition to experiencing symptoms similar to female sexual victims, several issues are specific to males.

The first, mentioned by virtually every clinician interviewed, is confusion about sexual identity. Since the male victim has most often been abused by an older male, the child concludes that he must be "gay" or that something, at least, attracted this man to him. "There is such poor information available in our society about homosexuality, that virtually everybody I talk to, unless they are a professional, believes that if a man abuses a boy child, the adult male and the boy child have some sort of homosexual relationship, rather than perceiving it as an adult sexual attraction to or adult victimization of children" (Mitnick, 1985, cited in Porter, 1986, p. 11).

Finkelhor (1984) has looked at the question of a connection between childhood sexual abuse and later homosexuality. He found that male college students who had been victimized by older men were four times more likely to be currently engaged in homosexual activity than were their non-abused peers. Close to half of the male respondents who had been sexually victimized as a child by an older man were currently involved in homosexual activity. Finkelhor speculates that when a boy is sexually abused by an older male, the boy may label himself as homosexual, then behave consistent with that role. He also notes that this process would explain only a small portion of adult homosexuality.

Finkelhor's results are similar to those of Johnson and Shrier (1987) who found that half their sample of male adolescents who had been sexually abused by males identified themselves as homosexual. Further, the adolescents often linked their sexual orientation to the molestation experiences. In one study by Johnson & Shrier (1985) sexually abused adolescent males identified themselves as currently homosexual nearly seven times as often and bisexual nearly six times as often as the control group.

If the abuser is a woman, a boy typically feels foolish for reporting the abuse. Society tells male children that they are supposed to enjoy sex. If the experience(s) was not satisfying, the boy may question his virility and manhood. He may even be perceived as "gay" for his failure to enjoy the abuse (Porter, 1986). Another assault to the boy's masculinity is his inability to protect himself (Porter, 1986). Boys are supposed to be independent and capable of self-protection. "The bottom line is that society does not allow boys to be a victim and also keep their masculinity," summarizes Mary Froning, Psy.D., who is a therapist in private practice in Silver Spring, Maryland.

Coping Styles of Young Male Victims

Fight
- acting out, delinquency, tantrums
- promiscuity, highly sexualized behaviors, compulsive masturbation and sexual acting out
- acting super-responsible
- using food as a [illegible] (eating disorders)
- daydreaming, fantasy
- use of aggression
- mood swings, irritability
- overactivity
- fire setting

Flight
- run away
- marry young to leave home
- suicide or attempted suicide
- develop multiple personalities
- develop stress illnesses
- hypervigilant
- sleep disturbances
- regressive behaviors
- phobic behaviors

Numbing
- deny feelings
- live in constant state of shock
- dissociation
- use of alcohol/drugs
- school failure (due to inattention and withdrawal)
- self-mutilation (detracts from internal pain)
- depression

A second issue for victimized boys is a fear of becoming a perpetrator themselves. Even though most victims do not become perpetrators, a majority of perpetrators have a history of victimization. As information about the "cycle of abuse" has become common knowledge, some victimized boys fear that they might become an offender against their will.

For those that do become offenders, they must learn other ways to master their rage and helplessness. Being an abuser can mean being in control and having power over others (Porter, 1986). The sense of power and control can in turn reinforce the behavior, leading to further and more extreme forms of aggression. Some therapists perceive this cycle of aggression as similar to an addictive process in which the male victim-turned-perpetrator gets a "shot" of power only to become more depressed and eventually need a more powerful "dose" of aggression in order to feel capable and in control (Sebold, 1987).

The helplessness and anxiety can have longterm negative effects as well. For example, Johnson and Shrier (1987) found that these feelings are frequently re-awakened during the victim's later attempts at sexual activity, causing sexual dysfunction.

A third issue, not mentioned frequently in the literature but discussed by clinicians, is fear of AIDS. "I know of one boy who disclosed only because he was terrified that he may have contracted AIDS," states Susan Mayman, L.C.S.W., a therapist in private practice in Bethesda, Maryland. Kathleen Faller, associate professor at the University of Michigan School of Social Work, feels AIDS is more of an issue for parents. "Some have their children tested every six months. We have concerns for the girl victims, too, since we are aware of perpetrators who are HIV positive. There are 10 to 15 children we think have been exposed."

It is not unusual for victims to feel responsible for abuse, but this is heightened for boys who are not socialized to see themselves in a victim role (Blanchard, 1986). Therapists may find boys laden with guilt for not having done more to extricate themselves in a "manly" way from the abusive situation. Male victims may also feel additional guilt if they experienced an erection or ejaculation. Not understanding fully how sexual response happens, boys may assume these responses "prove" that they desired the experience.

Several clinicians interviewed noted that boy victims were more likely than girls to show generalized aggression. For example, Helen Rininger and Albert Duseault, Jr.,

social workers with the Sexual Abuse Treatment Unit at the Virginia Beach Department of Social Services have noted physical aggression and self-destructive behavior in their client population.

Rininger and Duseault were also among those who expressed the idea that the greatest impairment of trust resulted when boys were victimized by their mothers. "When the mother is the perpetrator," stated Duseault, "the victim's ability to trust is destroyed."

Assessment

What to Assess

Given the high incidence of physical trauma in sexually abused boys to date, it is especially important that boys suspected of being abused have a medical evaluation. This evaluation should be a detailed one, including examination of the anus and rectum as well as testing for AIDS and venereal diseases. The physician should record all bruises, lacerations and scars. If the boy is physically normal, the physician can reassure him about his physical condition (DeJong, 1985; Spencer & Dunklee, 1986).

Most therapists advise doing an assessment of the family. Carolyn Cunningham, Ph.D., director of the Violence Prevention Program at Glendale Family Services in California, mentions some important factors. "You need a great deal of information about the family's history. Look for intergenerational patterns of abuse. Motivation for treatment is very important. Children are referred by various institutions. What is the family's willingness to cooperate?"

The crux of the evaluation process, however, is the trauma assessment of the child. Several clinicians have developed conceptual models or guidelines for trauma assessment.

Ann Burgess (Burgess, Groth, Holmstrom & Sgroi, 1983) has proposed an information processing trauma model, with four major phases. Phase 1 is the Pre-Truama and encompasses the time period prior to the boy's sexual abuse. The therapist needs to understand the child's functioning and development prior to the abuse. Important factors include the child's personality development, the structure of the child's family, sociocultural factors and history of prior traumatic life events.

Phase 2 is Trauma Encapsulation. Here the clinician needs to learn about all activities relevant to the abuse and exploitation of the boy. Key factors of offender behavior include how the offender gained access to the boy, how the offender controlled the child, the range of sexual activities, whether the child witnessed sexual activity or exploited others, and the strategies used to maintain secrecy and prevent disclosures.

Offender behaviors are responded to by the coping and defensive responses of the child. The therapist must determine what trauma learning (sensory, perceptual or cognitive) is associated with the event. Trauma learning is the basis for self-defeating patterns. Trauma replay, similar to a "flashback," where the child re-enacts the abuse, can occur. As the abuse continues, it is "encapsulated" and disguised to avoid detection. The therapist needs to assess the degree of encapsulation and the frequency of trauma replay.

Phase 3 is Disclosure. Disclosure is upsetting to the boy victim as it requires the breakdown of defensive structures in order to retrieve information. The therapist needs to assess the degree of stress caused by disclosure and subsequent interactions with family, agencies and the community.

Phase 4 is Post-Trauma Outcome. A boy can choose one of six responses:integrated, anxious, avoidant, disorganized, aggressive or delinquent. An *integrated* child is able to talk about the events, shows minimal distress, has control of aggressive and sexual thoughts, believes the offender is in the wrong and responsible for the abuse, views criminal prosecution positively, makes adjustments with family, friends and peers, and is future-oriented. The *anxious* pattern involves guilt and self-blame. Victims show unstable family relationships and poor socialization, often preferring younger playmates. They may continue sexually explicit behaviors, drop out of activities and be victimized again. The anxious victim is oriented to the past and feels hopeless about the future. The *avoidant* victim suppresses anxiety by denying the abuse, or denying memory of the abuse. The boy often has a stoic demeanor and avoids discussion. He manages his life as if nothing had happened. Under stress he may run away or engage in substance abuse. Relationships with peers and family may be strained, school difficulties are likely and minor antisocial acts may occur. The *disorganized* victim shows the most profound behavioral aberrations and is unable to distinguish reality and fantasy. In the *aggressive* pattern, the boy assimilates the anxiety caused by the abuse by impersonating the aggressor. This child minimizes the exploitation and resents interference of the authorities. The *delinquent* victim extends the aggressive patterns to the point of legal and school difficulty. Delinquent behavior can advance to criminal behavior, including sexual deviation.

The therapist should assess the child's current functioning to determine which of the six response styles is predominant.

A second conceptual model for trauma assessment is offered by David Finkelhor and Angela Browne (1985). They propose four traumagenic dynamics — traumatic sexualization, betrayal, stigmatization and powerlessness — as the core of the psychological injury inflicted by sexual abuse.

Traumatic sexualization is a process in which a child's sexuality is shaped in a dysfunctional and developmentally inappropriate way. If the offender rewards the child for sexual behavior (by attention or affection or material things), the child learns to use sex as a way of manipulating others to satisfy basic needs. If parts of the child are fetishized and given distorted importance, the child learns misconceptions about sexual behavior. If frightening memories are associated with sexual activity, then later arousal can activate the unpleasant memories.

Clinicians can evaluate the child's behavior to determine the degree of traumatic sexualization. Common manifestations are sexual compulsions and preoccupations, aggressive sexual behavior, phobic reactions or avoidance of intimacy, precocious sexual activity, confusion about sexual identity, and difficulty in separating affection and sex.

Betrayal refers to the discovery that someone who was supposed to care for the child instead caused him harm. Not only has the offender betrayed him, but there may be other adults who failed to protect the child who are part of the betrayal. Those who disbelieve, blame or ostracize the boy victim can be part of the betrayal. The psychological impact on the victim is often depression,

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Characteristics of Victimization of Boys

Incest

Father-Son Abuse

Other siblings also sexually abused
Father sexually abused as a child
Dysfunctional, chaotic family
Substance abuse by father
Physical abuse of wife and children

Mother-Son Abuse

Single mother
Both parents abuse son
Substance abuse by mother
Mother sexually abused as a child

Non-Family Abuse

Child socially isolated
Child from broken home
Child needs affection, care, shelter, attention
Child lacks parental supervision
Child emotionally troubled prior to abuse
Between ages of 9-17
Underachiever
No strong moral or religious affiliation
Lower socioeconomic class

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anger, hostility and the inability to trust. Betrayal leads to isolation, and raises the risk that the victim may be abused by another offender. Some victims act out the anger in a delinquent and aggressive fashion.

Stigmatization refers to the victim incorporating badness, shame and guilt into his self-concept. When the offender blames the boy and/or induces him to keep the abuse secret, stigmatization occurs. If the victim learns that the behavior is deviant or knows prior to the abuse that it is unacceptable, then stigmatization happens. The effects of stigmatization can be assessed by determining the degree of guilt and shame, and examining the victim's self-concept. Behavioral determinants are the degree of isolation, suicidal or self-injurious behavior, substance abuse and criminal involvement.

Powerlessness, the final dynamic, can also be termed disempowerment. If the child's body is invaded against his will, if coercion or manipulation is used by the offender, if the child tries to halt the sexual abuse but cannot, then powerlessness occurs. Obviously, the longer the duration of the sexual relationship, the greater the impact. The victim's reaction to powerlessness is anxiety and fear. Nightmares, phobias, somatic complaints and hypervigilance are common behavioral manifestations. Some victims compensate by identification with the aggressor.

In using Finkelhor & Browne's model, the clinician determines which specific dynamics were present and to what degree. The characteristics of the sexual experience(s) are examined for their contribution to each of the traumagenic processes. On the basis of the configuration of the four dynamics, the therapist can anticipate the likely effects of the abuse and the concerns of the victim. Interventions can be planned around these issues.

Finkelhor and Brown suggest that their model is more sensitive to the specific impact of sexual abuse than are broader psychological tests and inventories that relate to a variety of pathological conditions.

Gerber takes a different approach to trauma assessment. (For a complete program description, see Spotlight, this issue.) Gerber has identified 11 criteria that effect the degree of trauma, and, therefore, the intensity and duration of treatment. Summarized they are:

(1) presence of bizarre or ritualistic sexual acts;
(2) gross paraphillic behaviors such as fetishes, or sadistic/masochistic acts;
(3) threats of harm or physical injury;
(4) victim used to recruit other victims into group sexual activity;
(5) a long, covert pre-sexual conditioning process;
(6) victim has prior serious personality problems;
(7) victim uses force to solve interpersonal conflicts;
(8) erotization;
(9) victim lives in a dysfunctional family;
(10) victim has history of substance abuse;
(11) abuse by family member(s) and victim is very passive and dependent, causing difficulty with placement or removal from home.

The presence of these factors increases the degree of trauma. Generally, these factors will result in the need for longer and more intense treatment.

How to Assess

Clinicians vary considerably in the degree of structure used in making assessments. The format offered by Jane McNaught, Ph.D., a licensed consulting psychologist in private practice in Minneapolis, is an excellent one.

First, McNaught obtains backgound information. This includes information from police and child protective services, and all prior statements. (Mayman stresses the importance of waiting until after the police and CPS investigation to begin the assessment. "A clean and thorough investigation, uninterrupted by evaluation could be crucial in later court action.") Complete family information is gathered in order to look at the boy's and family functioning over time. "The child's prior emotional health affects the degree of trauma," explains McNaught. "And the identity of the perpetrator is also important. Thus, the clinician needs to understand the boy's relationship to the perpetrator prior to the sexual abuse."

In evaluating the child, time initially is spent building rapport. Psychological testing is undertaken first, with the primary instruments being drawings, the Rorschach and either the Children's Apperception Test (for younger children) or Murray's Thematic Apperception Test.

"Drawings are a good way to learn about the child's images of the abuse," states McNaught. "I prefer a procedure that uses a series of drawings." McNaught first asks the boy to draw his favorite weather. This is non-threatening and allows the examiner to assess the mood of the child. Second, the boy is asked to draw a picture of his entire self. She inquires about how old he is in the picture, and what the boy is thinking, doing and feeling. The third drawing is a picture of the victim and his family doing an activity together. In the fourth drawing, the boy is asked to draw a house and a tree. The fifth drawing is a picture of the sexual abuse, "what happened to you." The last drawing is free choice.

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Abuse of Boys

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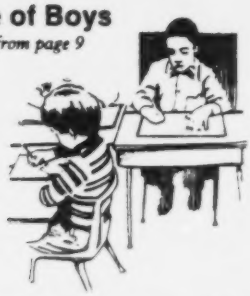

Other clinicians suggest the use of anatomically correct dolls to assist the male victim in verbalizing the events. Mayman frequently uses the dolls. "Even with adolescents this can be easier," she states. "I also encourage the adolescent victim to write out an account."

The purpose of the assessment is to identify the victim's defensive structure as well as current perceptions of the world. Utilizing Ann Burgess' theoretical framework, "the therapist needs to unlink trauma at the sensory, perceptual and cognitive levels from dysfunctional behavior," explains McNaught.

An interview is used to learn more about the sexual abuse. "The nature of the abuse, interacting with the child's characteristics, will determine the effects. The type of sexual contact, alone, does not determine the level of impact. The child's cognitive and emotion orientation is important," states McNaught.

It is also important to assess the child's safety and ongoing contact with the perpetrator. The family assessment is crucial in this determination, but the boy's knowledge about personal safety is also a factor.

Marianne Celano, Ph.D., formerly with the Division of Child Protection of Children's Hospital National Medical Center, has developed a series of hypothetical questions to access child safety for boys ages four to eight. Starting with common, practical problem-solving, the questions move to situations of inappropriate touch and then end with a neutral question.

Her questions are: What would you do if ... your younger brother got lost in a store? ... a smaller child tries to pick a fight with you? ... you find a wallet in a store? ... a bigger boy said to give him money or he will beat you up? ... you lost your mother an an amusement park? ... a man offered you $5 to come into his car? ... you walked in the bathroom and saw two boys fighting? ... a boy at school rubbed you or touched you on purpose in your private place? ... a man you know wanted to show his penis to you? ... you found a lost puppy?

Celano comments, "You get a sense of how realistic the child's responses are. Boys who are at risk for sexual abuse tend to give unrealistic or inappropriate responses." Celano uses the responses to help judge how much a child can protect himself from potential abuse. The responses also help with the parent conference and assist in treatment and prevention training.

Residential placement or foster care can be considered for cases where the child's safety is in question. This option is also available for those victims whose current functioning demands a very supportive atmosphere. A case where the victim needs substance abuse treatment is one example. Froning cautions that clinicians should inquire about substance abuse even with young children. "Even at nine or 10 you need to worry about drugs and alcohol. The offender may have introduced the boy to substances, then the victim seeks them out in order to numb feelings. Ask the parents to be aware of the possibility, to check their liquor supply for example, especially if they are noticing mood swings in the child."

If the child victim is offending against other children in the family, placement is also an option. However, few placements are available that limit the child's access to other children. "Kids repeat offenses in foster care or residential treatment," notes Cunningham. "If a child has a history of sexual acting out, he should be the only child in the foster home."

Children who are less seriously traumatized share common characteristics. Jan Hindman, a therapist in private practice in Minnesota, described those with minimal damage. "All were abused with the understanding that they were victims and that the offender was responsible for the abuse. These children reported the sexual contact quickly, and received a positive response to disclosure. Finally, these victims devised a way to separate the sexual abuse from normal sexual development."

Jan Hindman

Treatment

While some maintain that therapy is not always necessary (Blanchard, 1986), most sources feel that counseling is a necessity. Those who feel that therapy may not be needed for some children cite a lack of symptoms and supportive environments as counter-indications for therapy. Those who feel that counseling is often necessary note that boys, in particular, mask symptoms, deny problems and may appear well adjusted until problems such as sexual acting out surface. Thus, clinicians should be cautious when assuming that a male victim is not in need of treatment. A careful assessment may be therapeutic, and can provide a data base for later treatment, if a decision not to treat is made.

Choice of Modality

Group treatment appears to be the preferred modality. Group work can break the child's isolation, reduce the negative effects of secrecy and remove feelings of being "different." Learning from others, positive modeling and supportive friendships can occur in the group setting.

Individual therapy, on the other hand, can recreate some of the dynamics involved in the sexual abuse. In both the molestation and the individual therapy session, the boy is alone with someone who discusses sexual and intimate matters. The confidentiality offered in therapy may appear to the child like the secrecy of the abuse. The boy may fear that the therapist also expects sexual favors or may confuse emotional caring on the part of the therapist with sexual interest.

Despite the obvious benefits of group therapy, individual work may be the only choice. In smaller rural areas, there may not be a sufficient number of identified victims of the same age at the same point in time to form a group. In other cases, group therapy may be too threatening to the boy victim due to the fear of ridicule or other concerns. More seriously disturbed boys who are extremely depressed, suicidal, self-mutilating or psychotic may be unable to function in a group. If the child has been assaulted by a group, the idea of group therapy may reactivate fears of assaults. Individual therapy may also be beneficial in conjunction with group therapy.

An alternative to group therapy has been tried by Mayman. She has found dyad work (getting two boy victims together) has been a very beneficial technique when the boys have expressed an interest in talking with others who have been through similar experiences.

Family therapy appears to be an equally important modality, especially work that occurs with the father. If the father is not the offender, he is crucial to the recovery process, as he is likely the most important sex-role model for his son. The father can be ambivalent and undermining of treatment if he avoids dealing with his son's molestation and the effects of that sexual experience (Porter, 1986). Fathers can be difficult to engage in treatment. Froning tells of one father she saw in his car in the parking lot. "I could not induce him to join us in my office. He was unable to be supportive." If a father does involve himself in treatment he can be a powerful figure in assisting his son to accept his vulnerability and feel confident that he will heal.

Parents typically need much information about sexual abuse and its impact. They need to express their ideas and ventilate feelings. Parents often share the boy's feelings about homosexuality, vulnerability and public

exposure. Without a working alliance with the therapist, parents are likely to deny their own fears and withdraw their son from treatment.

Parent support groups can be very helpful in decreasing isolation and "normalizing" the victimization. Some clinicians (Porter, 1986) suggest support groups just for fathers, as their concerns are somewhat different than those of their wives.

Treatment Tasks

The first task of treatment is to ensure safety for the child victim. It is important to consider that some children are victimized by multiple abusers or become vulnerable to additional abuse. If the boy has abused other children, measures need to be taken to ensure that he is not dangerous to other children.

It is important that the therapist convey the message that he or she has the capacity to deal with the abuse. Mayman notes, "You have to be able to hear it. Be aware of your own countertransference issues. With boys there can be a very strong reaction."

The boy must be encouraged to talk candidly about what occurred. Clinicians agree that this is the most difficult task.

Froning suggests that one reason underlying a boy's denial is the propensity to become an abuser himself. "You think you have a victim, but sometimes they are reactively abusing other children. They feel so guilty about their own sexually aggressive behavior that they cannot tell you about their victimization they experienced."

While noting the importance of talking, most clinicians stress allowing the boy to control the timing and pace of revelation. Porter (1986) states that the boy must "be empowered to protect himself from intrusion and be prepared to handle the emotions that go with a discussion of what happened to him . . . Any attempts to force the youth to talk are destructive, particularly insofar as they represent an acting out of the worst elements of the assaultive situation" (pp. 44-45). Others agree. Mayman comments, "It's real important not to push, but to provide a safe pace for disclosure." Gerber, on the other hand, takes a proactive stance. "Avoiding the sexual abuse makes it shameful," he states. Gerber advocates asking very explicit questions about sexual activity in order to get a more complete version of the activity.

Even though he cautions against forced disclosure, Porter agrees with a directive approach. The therapist must provide structure that allows sexual discussion to occur, as most boys will not volunteer details. By speaking frankly and systematically, a therapist can demystify sexual conversation, model ways to talk about sex and communicate willingness to hear.

Other techniques include the use of anatomical dolls, drawings and writing a journal account. Froning uses a desensitization process, talking about the abuse a little at a time. For those who have dissociated from or repressed the events, Froning uses hypnosis to help boys recover memories. "You need to wait with hypnosis until they are ready," explains Froning, "or the procedure will not satisfy much. A boy is ready to use hypnosis when he has accepted that the incidents have happened and when the symptoms are worse than the impact of remembering."

Still, patience is needed. Froning tells of a boy who denied being a victim for 15 months even though everyone in the child's family was openly supportive about disclosing the abuse. Mayman adds, "It takes months for these boys to trust and feel safe."

Once the boy is able to divulge the details, the next task is getting in touch with feelings. Porter maintains that boys are not so much uncomfortable with feelings as simply ignorant of them. Lacking tools to recognize and express the pain, the boy becomes at high risk for acting out the abuse.

Jane McNaught, Ph.D.

The most usual feelings are anger, guilt and fear. The male victim is most likely to be aware of the anger. Gerber comments, "Boys don't need so much to be angry. They know how to do this and have cultural permission. Boys need to cry." Faller agrees. "Boys are in touch with anger often and can express it. Sometimes the expression is animal torture or physical abuse of others. Then re-directing the anger is necessary."

Porter notes that powerlessness lies behind the anger. Anger can mask the "soft" emotions of sadness, betrayal, grief and loneliness. The therapist must assist the boy in expressing rage without aggression. Role play, the use of symbolic objects on which to focus the anger (such as photographs, drawings, punching bags, etc.), or confrontation of the perpetrator are possible outlets.

Guilt can involve feeling responsible for the sexual abuse or for the negative impact of disclosure on the perpetrator. If the boy was aroused or experienced orgasm, if he took money or presents from the perpetrator, if he indulged in substance abuse, looked at pornography or solicited other children for the abuser, then the boy is likely to feel intense guilt. Guilt is also a way of denying vulnerability, since responsibility implies control. If the boy has acted sexually towards other children, guilt is more intense as the anger felt towards the abuser is also turned inward. Froning notes, "Boys are more likely to be abused by pedophiles. These offenders get the victim drunk, show him pornography and do anything to actively engage the child in the sexual encounter. It is akin to an incest situation in terms of the victim's level of guilt."

Porter cautions that disempowerment can occur if victims are told they are not responsible for their own behavior. While the responsibility for the *molestation* is the offender's, the victim can be held responsible for his own actions, correcting his own behavior and making amends if he has also hurt others.

A common fear is the issue of homosexuality. Faller notes, "The issue of sexual identity is hard to handle. The kids won't talk about it, so you have to introduce it. It's a real dilemma. Some boys who are sexually abused will later identify themselves as homosexual." Thus, the therapist must reassure the boy that molestation does not *cause* homosexuality but at the same time the therapist must give the client permission to choose his sexual orientation.

Tackling the issue of homosexuality often means education about sexuality — both normal and deviant. Many victims lack knowledge about sexual development and functioning. Victims also need to learn what is known about why people molest children. Sex education remains a controversial subject with the general population. Thus, the form and content of sex education must be developed in consultation with the boy's parents.

Porter (1986) outlines an agenda for teaching healthy sexuality. His goals include instilling a concern and respect for the rights of others. The healthy person shows sufficient self-love to allow enjoyment of sexual pleasure without guilt or negative emotions. A third goal is understanding sexual physiology and the range of sexual behaviors. Mayman adds practical items. "Adolescent boys need to learn how to handle their normal sexual feelings. They are often dealing with dating or thinking about dating and becoming sexually active."

The task of identifying feelings can take a long time. One useful tool is a simple list of feeling words which can be thrust into the boy's hands as he utters the inevitable "I don't know." The boy can then pick the ones that come closest to what he is feeling (Porter, 1986).

The therapist should not neglect the positive feelings of caring between victim and offender. Validation of his need for affection and intimacy can be offered, along with distinguishing affection from sex. Interactions with the therapist can be crucial in this distinction.

Merely identifying feelings is not sufficient. Having labeled and explored feelings, they must be connected, along with any behavioral problems, to the abusive events.

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This step is seen as crucial in avoiding the cycle of abuse and avoiding the compulsive self-destructive behaviors and self-hate common in untreated adults.

Having linked the symptoms to the sexual abuse, the next task is to help the boy see that the self-protective defenses are no longer needed. Negative behaviors are tackled and altered. Confidence and self-esteem improve as the boy is empowered through mastery of his behavior.

This process often involves changes in relationships. The boy learns how to establish proper boundaries. Trust in others is restored. Isolation has been lessened. The offender has been confronted, either in person or symbolically. If the offender is still in contact with the boy, there is some control in place to assure the boy's continued safety. The boy has also received prevention training to assist him in avoiding further abuse.

Structuring the Group

A model for group therapy is offered by Porter (1986). He feels there are three stages in the group: creating a sense of cohesion, "working through" issues and termination.

During the first stage of the group, the task is to create norms of behavior that allow for safety and respect, plus a clear contract for working on the issues. Porter describes this as an active creation which starts the empowerment process. Therapists work to ensure that each group member feels protected and connected.

Therapists are also active in this first stage, encouraging interaction via "getting to know you" exercises such as having members interview each other. Victimization is also addressed, as specified in the contract agreed to by each boy prior to entering the group. During the fourth session each member discusses his molestation. It is rare for a group member to be unsupported by others at this point. A "Tell My Story Chart" assists the boy in this task. Fears are actively labeled and discussed.

One way of facilitating bonding and of creating nurturing, positive experiences is to go on outings. The group plans and executes the outings.

Stage two involves working through the issues of power, sexual identity, intimacy and guilt. Termination varies according to each individual. It is seen as a stopping point that is not necessarily permanent, allowing for the resumption of treatment if needed.

Termination

When clinicians were asked how to determine when to end therapy, the response was universal — "When the boy can comfortably talk about the abuse and is symptom-free." Others mentioned the need for the child to have developed positive relationships and to be able to identify help sources. Froning mentioned the need for the parents to have worked through issues, gained understanding of their son and learned how to support his progress.

Abuse-Reactive Children

Several clinicians stressed the importance of the victim/offender cycle of behavior. Porter commented, "In my earlier work, I didn't recognize how many victims have acted out sexually with younger children."

Noting that males are socialized to act, rather than talk, Mayman feels the victim who becomes a perpetrator is trying to master the experience non-verbally. When the boy's anxiety level raises due to fear of attack, humiliation or abandonment, he overcomes his helplessness by harming another. By being the aggressor, the boy replaces the anxiety with feelings of power and achieves tension release. Cunningham notes that failure to master the trauma will create a continual need to re-create and re-enact it throughout adult life.

Clinicians note that sexual acting out by victimized boys may be minimized or ignored by parents and professionals alike. Faller explains, "Sexual acting out often gets defined as 'play.' Then it gradually changes from hypersexual behavior to more aggressive sexual behavior. It is a very gratifying activity for the child and once the behavior becomes repetitive and compulsive it is very difficult to stop." Froning adds, "Parents want to think the sexual behavior is normal curiosity, but the sexual activity is generally not like the exploration that nonvictimized children do."

Assessment of sexualized acting out is not easy. Reports by parents and others are very helpful. Celano also suggests exploring the boy victim's fantasy of "getting back" at the offender. "If the boy demonstrates a lot of rage and sexualized aggression, I worry." Celano asks boys about their "get back" fantasy, and if they have ever acted on it. She asks what they think would happen in real life if they did the fantasy behavior. Attaching realistic consequences to aggression may prevent the boy victim from acting out and/or rationalizing sexual aggression, a pattern which has been observed among juvenile sex offenders. Cunningham suggests examining other related behavioral problems as well, especially fire setting and cruelty to animals, which can be warning signals that a child is at risk for becoming a perpetrator. With younger children, Froning observes their play. "They will identify with victim feelings or aggressor feelings."

Environmental intervention can be important, especially in the early stages of therapy. Froning notes,"If an older child is abusing siblings, parents must do a lot to supervise their contact. If the parents are not capable or motivated, protection within the home may not be possible." Celano reports that many of the families she assessed were multiproblem and unmotivated for treatment. "Our population was low income, and often one or more family members were substance abusers. When the environment includes adults who are engaged in 'crack' dealing and prostitution, removal of the child is considered to be the only option."

Cunningham directs a program for abuse-reactive boys, and has co-authored a treatment guide for the abuse-reactive child (see review, this issue of "Steps to Healthy Touching").

Cunningham explains the program philosophy. "My sense about these boys is that they either have been molested or else they have seen a lot of sexual activity in their families. Sex becomes an addictive cycle for them, often times by adolescence."

Noting the young age of many of her clients, Cunningham stresses that treatment must be non-threatening. "The boys do not want to talk about the sexual activity. It's too scary for them. The therapist has to introduce the topic."

Cunningham's program teaches children to contain their impulses. She makes liberal use of rewards, praise and stickers to encourage the boys to participate. "We are always looking for ways to adapt materials and keep the sessions interesting," states Cunningham.

Clinicians agree that behavioral control is a key to successful resolution of the therapy. Porter explains, "Acting-out behaviors keep the child from feeling, so he never connects with the issues. When the child stops acting-out, then feelings emerge and become assessible."

A parent group meets concurrently with the children's group. Faller agrees that parental involvement is important. "I work

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Creating a Climate That Allows Boys to Disclose Sexual Abuse

- Question children referred for aggressive, acting out behavior about the possibility of prior sexual abuse.
- Educate children about the possibility of males being victims.
- Question all siblings when abuse of one child is discovered.
- Offer male victims the same level of protection, treatment and concern as females.
- Have access to materials and resources designed for male victims.
- Educate those working in rape crisis and other hotlines about male sexual victimization. Recruit male survivors to assist.
- Counter the prevailing sex-role myths about the invincibility of the "real man" with more realistic roles for boys to emulate.
- Encourage older males to speak out about victimization experiences.

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with the family to get a risk-free environment," she states. "The family is crucial in helping the child 'keep a lid' on his impulses."

Cunningham's program also focuses on the child's own victimization. "The therapy goes back and forth. We work on the victimization, then on the acting-out, and so on." Faller notes that the child who can discuss his own victimization can get in touch with the pain, and can then empathize with potential victims. It can even help to bring the child's victim in to confront him.

Ballester and Pierre offer a similar therapy program, described in this issue (See "Spotlight: Monster Therapy"). Relapse is always a concern. All clinicians stressed the importance of helping the child and parents identify high-risk situations and warning signs. Cunningham stressed having the children return for check-ups. "I see this behavior as similar to a drug addiction cycle. It is likely to recur and needs monitoring."

Virginia's Picture

Four clinicans in Virginia were interviewed about their treatment experience with male victims. They varied in their focus on sexual abuse from 100 percent of their work to 30 percent. All replied that, of the sexually abused children seen in their practice, approximately 15 percent were male.

Three of the four clinicians perform a trauma assessment. Some, such as Jackie Supp, therapist with Richmond's Child and Family Unit, use the trauma assessment to structure the therapy. Group therapy is the treatment of choice, but none of those interviewed were aware of group treatment for boy victims in their area. The clinicians interviewed prefer a lengthy treatment of a year or more. Isacc Van Patten, a private practitioner from Roanoke, stressed that there is no termination of cases. Boys are encouraged to return as needed. VCPN would like to hear from programs in Virginia specific to male victims. Social service departments contacted by VCPN are making individual referrals to mental health practitioners for individual and/or family therapy.

System Response

Currently, helping systems have failed many, if not most, male victims of sexual abuse. At the most basic level, that of protection, the system responds much differently to boys than to girls. For example, one study found that only four percent of boy victims, compared to 20 percent of girl victims, were removed from the perpetrator as a precaution against further abuse (Pierce & Pierce, 1985).

Services for boys differ from those offered to girls as well. Courts rarely order treatment for boys. Studies show that few boys receive a medical evaluation. Psychological treatment is not sought frequently for victimized boys. When boys do receive treatment, they are seen for shorter time periods than females. For example, in Pierce and Pierce's survey (1985), the majority of treated boys were seen for less than four months.

Prevention

Prevention of sexual abuse of boys may be a more complex task than preventing sexual abuse of girls. Society needs to recognize males as victims and educate the general public and children about the possibility that "it can happen to boys, too." The concept that "a true male is never a victim" needs to be corrected.

Boys must be rewarded for disclosure, and professionals need to learn about the unique aspects of working with abused males. Adult males who have been victims as children and who speak out and are visible might be valuable role models for younger boys.

Prevention efforts must extend to boys. There is an acute need for prevention materials that are written for boys. Prevention materials for teenage boys are noticeably lacking.

All children, boys and girls, deserve nurturing and protection. *All* children, boys and girls, deserve the opportunity to grow free of victimization.

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